AE SAFELY REDUCE HOSPITALIZATIONS TRACKING TOOL

June 25, 2013
Are you registered for the Advancing Excellence in America’s Nursing Homes Campaign?

• Yes
• No
About the Campaign

National, Voluntary, Aligned

Registered Participant
⇒ Register/Update Profile
⇒ Select Goals

Active Participant
⇒ Submit Data

www.nhqualitycampaign.org
Quality Improvement Resources for NINE Goals

- Hospitalizations
- Staff Stability
- Pressure Ulcers
- Medications
  - Antipsychotics
- Consistent Assignment
- Infections
  - C. difficile
- Mobility
- Person-Centered Care
- Pain Management
Organizational Goals

- Hospitalizations
- Staff Stability
- Pressure Ulcers
- Medications
  - Antipsychotics
- Consistent Assignment
- Infections
  - C. difficile
- Mobility
- Person-Centered Care
- Pain Management
Poll

Are you using INTERACT Tools?

• Yes
• No
How do I know where I am?

Where do I want to be?

What processes are associated with my outcome?

When I change a process, how do I know it had the effect I wanted?
<table>
<thead>
<tr>
<th>Quality Assurance</th>
<th>Performance Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reactive</td>
<td>Proactive</td>
</tr>
<tr>
<td>Episode or event-based</td>
<td>Aggregate data &amp; patterns</td>
</tr>
<tr>
<td>Prevent recurrence</td>
<td>Optimize process</td>
</tr>
<tr>
<td>Sometime anecdotal</td>
<td>Always measurable</td>
</tr>
<tr>
<td>Retrospective</td>
<td>Concurrent</td>
</tr>
<tr>
<td>Audit-based monitoring</td>
<td>Continuous monitoring</td>
</tr>
<tr>
<td>Sometimes punitive</td>
<td>Positive change</td>
</tr>
</tbody>
</table>
• Easy view of individual records allows resident-level RCA of events

• Matrix of individual data allows scanning for patterns

• Summary information helps identify opportunities to improve communication and optimize processes at the system level
The Tracking Tool

AE_SafelyReduceHospitalizationsTrackingTool.xls

www.NHQualityCampaign.org
3 - For Residents Recently Discharged from Hospital
   - Resident name
   - Date discharged from hospital
   - Status on admission to nursing home from hospital (Part A, Other)

4 - For Residents Transferred to Hospital
   - Resident name
   - Purpose of nursing home stay
     (PAC-type Care/Chronic Long Term Care)
   - Date of transfer to hospital
   - Outcome of transfer

1- For Your Home (or the group within your home you are tracking)
   - ADC (or mid-month census) by purpose of stay
### Data Entry & Highlighted List of Residents in 30-day window

#### Admitted with Recent Discharge

Step 3: List all admissions to your nursing home from hospital or who were discharged from a hospital within 30 days of admission to your nursing home. Fields with red asterisk (*) are required. This information will be used to calculate your 30-day rehospitalization rates.

**Today’s Date: 05/15/2013**

Watch these residents. They are at risk of rehospitalization within 30 days. These residents were re-admitted to hospital within 30 days of admission to NH: RCA indicated.

Which admissions should I record?

<table>
<thead>
<tr>
<th>Automatic Resident Code</th>
<th>Resident Name</th>
<th>Hospital Discharge Date</th>
<th>Date Admitted to NH</th>
<th>Automatic Day of Week</th>
<th>Status on Admission to Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>88</td>
<td>Josie Leite</td>
<td>03/10/13</td>
<td>03/15/13</td>
<td>04/01/13</td>
<td>Chronic Long-term Care (Not Medicare Part A)</td>
</tr>
<tr>
<td>89</td>
<td>Karen Macdonald</td>
<td>03/10/13</td>
<td>03/15/13</td>
<td>04/01/13</td>
<td>Chronic Long-term Care (Medicare Part A or managed care)</td>
</tr>
<tr>
<td>91</td>
<td>Caleb Medley</td>
<td>04/01/13</td>
<td>04/04/13</td>
<td>04/01/13</td>
<td>Post-acute Care (Medicare Part A or managed care)</td>
</tr>
<tr>
<td>92</td>
<td>Cindy Ballantine</td>
<td>04/04/13</td>
<td>04/04/13</td>
<td>04/01/13</td>
<td>Post-acute Care (Medicare Part A or managed care)</td>
</tr>
<tr>
<td>93</td>
<td>Dale Gallery</td>
<td>04/04/13</td>
<td>04/04/13</td>
<td>04/01/13</td>
<td>Post-acute Care (Medicare Part A or managed care)</td>
</tr>
<tr>
<td>94</td>
<td>Becky Asmus</td>
<td>04/04/13</td>
<td>04/04/13</td>
<td>04/01/13</td>
<td>Post-acute Care (Medicare Part A or managed care)</td>
</tr>
<tr>
<td>95</td>
<td>Dulce Man</td>
<td>04/04/13</td>
<td>04/04/13</td>
<td>04/01/13</td>
<td>Post-acute Care (Medicare Part A or managed care)</td>
</tr>
<tr>
<td>96</td>
<td>Ellicore Carmosche</td>
<td>04/04/13</td>
<td>04/04/13</td>
<td>04/01/13</td>
<td>Post-acute Care (Medicare Part A or managed care)</td>
</tr>
<tr>
<td>97</td>
<td>Elke Rose</td>
<td>04/04/13</td>
<td>04/04/13</td>
<td>04/01/13</td>
<td>Post-acute Care (Medicare Part A or managed care)</td>
</tr>
<tr>
<td>98</td>
<td>Fred Hoole</td>
<td>04/04/13</td>
<td>04/04/13</td>
<td>04/01/13</td>
<td>Post-acute Care (Medicare Part A or managed care)</td>
</tr>
<tr>
<td>99</td>
<td>Gerardo Malton</td>
<td>04/04/13</td>
<td>04/04/13</td>
<td>04/01/13</td>
<td>Post-acute Care (Medicare Part A or managed care)</td>
</tr>
<tr>
<td>100</td>
<td>Haley Hill</td>
<td>04/04/13</td>
<td>04/04/13</td>
<td>04/01/13</td>
<td>Post-acute Care (Medicare Part A or managed care)</td>
</tr>
<tr>
<td>101</td>
<td>Jerel Davila</td>
<td>04/04/13</td>
<td>04/04/13</td>
<td>04/01/13</td>
<td>Post-acute Care (Medicare Part A or managed care)</td>
</tr>
<tr>
<td>102</td>
<td>Jerald Rothchild</td>
<td>04/04/13</td>
<td>04/04/13</td>
<td>04/01/13</td>
<td>Post-acute Care (Medicare Part A or managed care)</td>
</tr>
<tr>
<td>103</td>
<td>Joseph Kindel</td>
<td>04/04/13</td>
<td>04/04/13</td>
<td>04/01/13</td>
<td>Post-acute Care (Medicare Part A or managed care)</td>
</tr>
<tr>
<td>104</td>
<td>Kayley Kingsland</td>
<td>04/04/13</td>
<td>04/04/13</td>
<td>04/01/13</td>
<td>Post-acute Care (Medicare Part A or managed care)</td>
</tr>
<tr>
<td>105</td>
<td>Kevin Montalvo</td>
<td>04/04/13</td>
<td>04/04/13</td>
<td>04/01/13</td>
<td>Post-acute Care (Medicare Part A or managed care)</td>
</tr>
<tr>
<td>106</td>
<td>Kurt Boragan</td>
<td>04/04/13</td>
<td>04/04/13</td>
<td>04/01/13</td>
<td>Post-acute Care (Medicare Part A or managed care)</td>
</tr>
</tbody>
</table>

Select the drop-down menus to view specialty hospitalization rates.
## Data Entry Step 3

### Transfer Log

**Step 4:** Complete the detail for each resident transferred from your nursing home to hospital in the grid below.

- **Highlight indicates resident had an unplanned admission to the hospital within 30 days of discharge from hospital.**
- **Not all transfers result in admission.**
- **Include ONLY transfers to acute care hospitals or critical access hospitals.**
- **Red asterisk indicates required field.**

#### About this Resident

<table>
<thead>
<tr>
<th>Resident Name*</th>
<th>Purpose of Nursing Home Stay*</th>
<th>Payment Status at Time of Transfer from Nursing Home to Hospital</th>
<th>Date of Transfer to Hospital*</th>
<th>Transfer: Time of Day*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adena Blinn</td>
<td>Post-Acute Type Care (Rehab/Medical Management)</td>
<td></td>
<td>4/25/13</td>
<td></td>
</tr>
<tr>
<td>Annabelle Soll</td>
<td>Chronic Long-term Care</td>
<td></td>
<td>4/6/13</td>
<td></td>
</tr>
<tr>
<td>Byron Centeno</td>
<td>Chronic Long-term Care</td>
<td></td>
<td>4/30/13</td>
<td></td>
</tr>
<tr>
<td>Nubia Arch</td>
<td>Chronic Long-term Care</td>
<td></td>
<td>4/30/13</td>
<td></td>
</tr>
<tr>
<td>Phil Laber</td>
<td>Chronic Long-term Care</td>
<td></td>
<td>4/23/13</td>
<td></td>
</tr>
<tr>
<td>Roba Swanson</td>
<td>Post-Acute Type Care (Rehab/Medical Management)</td>
<td></td>
<td>4/15/13</td>
<td></td>
</tr>
<tr>
<td>Roy Ringdani</td>
<td>Chronic Long-term Care</td>
<td></td>
<td>4/11/13</td>
<td></td>
</tr>
<tr>
<td>Stewart Weatherall</td>
<td>Post-Acute Type Care (Rehab/Medical Management)</td>
<td></td>
<td>4/30/13</td>
<td></td>
</tr>
<tr>
<td>Kevin Maudilo</td>
<td>Chronic Long-term Care</td>
<td></td>
<td>4/25/13</td>
<td></td>
</tr>
<tr>
<td>Ethan Paul</td>
<td>Chronic Long-term Care</td>
<td></td>
<td>4/26/13</td>
<td></td>
</tr>
<tr>
<td>Eduardo Hernandez</td>
<td>Chronic Long-term Care</td>
<td></td>
<td>4/18/13</td>
<td></td>
</tr>
<tr>
<td>Casey Finder</td>
<td>Chronic Long-term Care</td>
<td></td>
<td>4/26/13</td>
<td></td>
</tr>
<tr>
<td>Gavin Langdon</td>
<td>Chronic Long-term Care</td>
<td></td>
<td>4/18/13</td>
<td></td>
</tr>
<tr>
<td>Edith Longshore</td>
<td>Chronic Long-term Care</td>
<td></td>
<td>4/20/13</td>
<td></td>
</tr>
<tr>
<td>William Moore</td>
<td>Chronic Long-term Care</td>
<td></td>
<td>4/20/13</td>
<td></td>
</tr>
</tbody>
</table>

*Resident Name:
- Example: Jane Smith

*Purpose of Nursing Home Stay:
- Post-Acute Type Care (Rehab/Medical Management)
- Chronic Long-term Care

*Payment Status at Time of Transfer from Nursing Home to Hospital:
- Select from dropdown list
- Enter name exactly as it appears on the drop down list

*Date of Transfer to Hospital:
- Example: 7/20/12

*Transfer: Time of Day:
- Select from list
How do I know where I am?
Identify Baseline

1. 30-Day Readmission Rate
2. Hospital Admission Rate
3. Rate of Transfers to ED Only
4. Rate of Transfers Resulting in Observation Stay
Patterns in Admissions from Hospital

- Day of week
- Hospital

Patterns in Transfers to Hospital

- Payment status at time of transfer
- Time of day
- Doctor ordering transfer
- Primary clinical reason for transfer
- Contributing

Process when Admitting from Hospital

- Structured communication tool used
- Information adequate to care for resident

Process when Transferring to Hospital

- Structured communication tool used when transferring to hospital
- RCA of transfer completed
- Documented ACP discussion in past quarter
- ACP reviewed at time of transfer
- Structured communication tool used at nursing home to evaluate acute condition
Patterns in Admissions *from* Hospital
- Day of week
- Hospital

Patterns in Transfers *to* Hospital
- Payment status at time of transfer
- Time of day
- Clinician ordering transfer
  - Primary clinical reason for transfer
  - Primary contributing reason for transfer

Process when Admitting *from* Hospital
- Structured communication tool used
- Information adequate to care for resident

Process when Transferring *to* Hospital
- Structured communication tool used when transferring *to* hospital
  - **RCA of transfer completed**
  - Documented ACP discussion in past quarter
  - ACP reviewed at time of transfer
  - Structured communication tool used at nursing home to evaluate acute condition
Use Data to Track Process Measures

**Transfer Related Processes**

- **Percent of All Transfers for which Resident had a Documented Advance Care Planning Discussion in the Past Quarter**
- **Percent of All Transfers in which Resident's Advance Care Plan was Reviewed at Time of Transfer**
- **Percent of All Transfers in which a Structured Communication Tool was Used at Nursing Home to Evaluate Acute Condition**
- **Percent of All Transfers for which a Structured Communication Tool was Used to Receive Information from Hospital when Resident was Last Admitted to Nursing Home**
- **Percent of All Transfers for which a Root Cause Analysis was Completed**
Use Data to Explore Patterns

Primary Clinical Reasons for Transfers

Tool Tip

INTERACT Change in Condition File Cards
INTERACT Care Paths
AE Goal Packages and Tracking Tools
Use Data to Explore Processes

Primary Contributing Reasons for Transfers

- Advance care plan not in place: 30%
- Practitioner unable to provide face-to-face: 25%
- Supplies/Resources: 20%
- Medication management: 15%
- Equipment not available: 10%
- Problems w/other: 5%
- AE & INTERACT Advance Care Planning
- INTERACT SBAR
- INTERACT NH Capabilities Checklist
Optional Fields Help
Monitor Implementation

Patterns in Admissions from Hospital
- Day of week
- Hospital

Patterns in Transfers to Hospital
- Payment status at time of transfer
- Time of day
- Clinician ordering transfer
- Primary clinical reason for transfer
- Primary contributing reason for transfer

Process when Admitting from Hospital
- Structured communication tool used
- Information adequate to care for resident

Process when Transferring to Hospital
- Structured communication tool used when transferring to hospital
- RCA of transfer completed
- Documented ACP discussion in past quarter
- ACP reviewed at time of transfer
- Structured communication tool used at nursing home to evaluate acute condition
Use Data to Track Process Measures

Transfer Related Processes

- Percent of All Transfers for which Resident had a Documented Advance Care Planning Discussion in the Past Quarter
- Percent of All Transfers in which Resident's Advance Care Plan was Reviewed at Time of Transfer

Timeline:
- January 2013 to December 2013

Graph showing trends from January to December 2013.
Optional Fields Help

**Identify Patterns**

Patterns in Admissions *from* Hospital
- Day of week
- **Hospital**

Patterns in Transfers *to* Hospital
- Payment status at time of transfer
- Time of day
- **Clinician ordering transfer**
- Primary clinical reason for transfer
- Primary contributing reason for transfer

Process when Admitting *from* Hospital
- Structured communication tool used
- Information adequate to care for resident

Process when Transferring *to* Hospital
- Structured communication tool used when transferring *to* hospital
- RCA of transfer completed
- Documented ACP discussion in past quarter
- ACP reviewed at time of transfer
- Structured communication tool used at nursing home to evaluate acute condition
Source of Admissions
The 5 places from which our nursing home most frequently admits residents with recent hospital stay
Transfers by Clinician
for the 5 clinicians who order the most transfers

- Jekyll: 20%
- Strangelove: 10%
- Watson: 5%
- Faustus: 5%
- Frankenstein: 0%
- Not recorded: 0%
Involving Partners with Data

Share data with staff

Share data with hospitals
Involving Partners with Data

Inverness Hospital

30-Day Readmission Rates

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Acute Care Readmissions</td>
<td>50.0%</td>
<td>48.0%</td>
<td>28.0%</td>
<td>42.0%</td>
<td>48.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Long Term Care (non-Medicare) Readmissions</td>
<td>31.0%</td>
<td>31.0%</td>
<td>25.0%</td>
<td>6.0%</td>
<td>9.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Creating Change
Involving Partners with Data
February 2013

Data for Website Entry

You may use this sheet to view your monthly transfer rates as soon as you've entered all of your information through the end of the month.

IMPORTANT: Your 30-Day Rehospitalization Rates for February 2013 will not be final until you have completed your Transfer Log through:

Sunday, March 31, 2013

On or after 03/31/2013:
- Print this page.
- Log in to the Campaign
https://www.nhqualitycampaign.org
- Select 'Enter My Data'
- Under Safely Reduce Hospitalizations, click "Submit Data" and enter the numbers below in the corresponding fields.
- Click "Submit" and check the screen for the confirmation message.
Thank You!

<table>
<thead>
<tr>
<th>February 2013</th>
<th>Status at Time of Admission from Hospital</th>
<th>Purpose of Stay at Time of Transfer to Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Residents with Date of Discharge from Hospital in This Month</td>
<td>Post-Acute Care</td>
</tr>
<tr>
<td>-----------------</td>
<td>------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Post-Acute Care</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td>Chronic Long Term Care (non-Medicare)</td>
<td>39.8%</td>
<td>29.4%</td>
</tr>
<tr>
<td>All Residents</td>
<td>30</td>
<td>30</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>February 2013</th>
<th>Resident Days This Month, Your ADC x the number of days in the month</th>
<th>Hospital Admission Rate per 1000 resident days</th>
<th>Rate of Transfers to Emergency Department Only per 1000 resident days</th>
<th>Rate of Transfers Resulting in Observation Stay per 1000 resident days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Acute Care</td>
<td>1092</td>
<td>2.7</td>
<td>2.7</td>
<td>2.7</td>
</tr>
<tr>
<td>Chronic Long Term Care (non-Medicare)</td>
<td>3000</td>
<td>4.6</td>
<td>2.3</td>
<td>1.6</td>
</tr>
<tr>
<td>All Residents</td>
<td>4172</td>
<td>4.1</td>
<td>2.4</td>
<td>1.9</td>
</tr>
</tbody>
</table>
Enter Summary Data on the AE Website

Select a month and year from the list to load any previously entered data for that year and enable data entry in the table. After entering data for a month, click the Submit button to save your data.

### Status at Time of Admission from Hospital

<table>
<thead>
<tr>
<th>Month</th>
<th>Post-Acute Care</th>
<th>Chronic Long Term Care</th>
<th>All Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>February</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>March</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>April</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>June</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>July</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>August</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>September</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>October</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>November</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>December</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Length of Stay at Time of Transfer to Hospital

<table>
<thead>
<tr>
<th></th>
<th>Post-Acute Care</th>
<th>Chronic Long Term Care</th>
<th>All Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Days This Month</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unplanned Hospital Admission Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of Transfers to Emergency Department Only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of Transfers Resulting in Observation Stay</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Submit  Clear
Getting Started with the Advancing Excellence Hospitalization Goal

Join us for a series of 3 webinars

**June 27 * July 18 * August 1**

**1:00-2:00pm MT**

This FREE series of 3 practicums is hosted by AE and is open for anyone who would like to participate.

Each practicum will include presentation/demonstration, open space for questions and discussion, and homework.
Thank You
For making our nursing homes better places to live, work, and visit!

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303-931-0027